

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5190

CERTIFICATE OF DEATH

65174

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newark (rural)		c. LENGTH OF STAY IN 1b 29 Yrs	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Newark		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route #1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		f. STREET ADDRESS Route #1	
3. NAME OF DECEASED (Type or print) First Amanda Middle E. Last Adkins		4. DATE OF DEATH Month 4 Day 26 Year 1960	
5. SEX Female	6. COLOR OR RACE AA	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/17/1889
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 70 Days 0 Hours 0 Min.	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Selby		14. MOTHER'S MAIDEN NAME Tabby Purnell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. INFORMANT Adam Adkins, Rt #1., Newark, Md	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio-vascular Disease DUE TO (c) Chronic Bronchial Asthma		INTERVAL BETWEEN ONSET AND DEATH Sudden Several Years 11	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/16/57 , 19____, to 4/18/60 , 19____, that I last saw the deceased alive on 4/18/60 , 19____, and that death occurred at 11:30 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Ivory U. Sully, Jr.		ADDRESS (Street, city or town, state) Flower St., Berlin, Md	
DATE SIGNED 4/29/60		DATE SIGNED 4/29/60	
PHYSICIAN'S NAME (Type) Ivory U. Sully, Jr., M.D.		Berlin, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/29/60	
22c. NAME OF CEMETERY OR CREMATORY St. Peters Cem		22d. LOCATION (City, town, or county) (State) Nr. Newark, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Thornton B. Jolley, Salisbury, Md		ADDRESS DATE MAY 3 '60	
24a. REC'D BY REGISTRAR DATE MAY 3 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1513

STATE OF OHIO

1513

IN SENATE,
January 15, 1913.
REPORT
OF THE
COMMISSIONER OF
THE
BUREAU OF
REVENUE,
FOR THE YEAR
ENDING
DECEMBER 31,
1912.
COLUMBUS:
THE
BUREAU OF
PRINTING,
1913.

THE
BUREAU OF
PRINTING,
COLUMBUS,
OHIO,
1913.

1
M
X
I
0
1

5188

65175

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Rayfield</u> Middle <u>Armstrong</u> Last <u>Armstrong</u>				4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 10 - 1860</u>	
9. AGE (In years last birthday) <u>60 3/4</u> yrs		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Safer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State of foreign country) <u>Snow Hill, md</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Furnell Armstrong</u>				14. MOTHER'S MAIDEN NAME <u>Harriett Bishop</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Madeline Armstrong, Snow Hill, md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardio-vascular disease</u> <u>422.1</u> DUE TO <u>skilled</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>skilled</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>skilled</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>Several years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>January 1959</u> to <u>4/6</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>April 11</u> 19 <u>60</u> , and that death occurred at <u>6:20 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Ivory U. Sully, Jr.</u> M.D.				22b. DATE SIGNED <u>4-12-60</u>			
22c. PHYSICIAN'S NAME (Type) <u>Ivory U. Sully, Jr. M.D.</u>				22d. ADDRESS <u>Berlin, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>				23b. DATE THEREOF <u>April 13/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Columbia Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Snow Hill, md</u>				(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Ginn</u>				25a. REC'D BY REGISTRAR <u>Charles S. Kraus</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	
ADDRESS <u>Snow Hill, md</u>				DATE <u>APR 13 '60</u>			

412

1

[Faint, illegible text from the reverse side of the document is visible through the paper. The text appears to be a medical or legal record, possibly a death certificate, with fields for name, date, and location.]

1

5183

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

65176

1. PLACE OF DEATH o. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X BERLIN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1 GRAHAM AVE.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>WALLACE DORSEY CROPPER</u>				4. DATE OF DEATH Month Day Year <u>APRIL 24 1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 16, 1890</u>		9. AGE (In years lost birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN BUSINESS</u>		11. BIRTHPLACE (State or foreign country) <u>NEWARK MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>SAMUEL CROPPER</u>				14. MOTHER'S MAIDEN NAME <u>SALLIE GAULT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-32-1189</u>		17. INFORMANT Address <u>MRS. W. D. CROPPER BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocarditis</u>							
DUE TO <u>2 Hypertension</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>1-1-55 4-24-60</u>	
21. I certify that (I) <u>this hospital</u> attended the deceased from <u>1-1-55</u> to <u>4-24-60</u> , that (I) (we) last saw the deceased alive on <u>4-5-60</u> and that death occurred <u>10:00 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Clifford E. Schott</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>CLIFFORD E. SCHOTT M.D.</u>				22d. ADDRESS <u>BERLIN, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/26/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		23d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Anna H. Burbage</u> ADDRESS <u>Berlin Md.</u>				25a. REC'D BY REGISTRAR DATE <u>APR 28 60</u>		25b. REGISTRAR'S SIGNATURE <u>Anthony J. Thomas</u>	

444X

0

1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
5189
M
65177
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Worcester</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>md</i> b. COUNTY <i>Worcester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>	
c. LENGTH OF STAY IN 1b <i>20 yrs</i>		d. STREET ADDRESS <i>1</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Lorenia</i> Middle <i>Davies</i> Last <i>Davies</i>		4. DATE OF DEATH Month <i>April</i> Day <i>18</i> Year <i>1960</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Caucasian</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan. 10 1906</i>	
9. AGE in years (lost birthday) <i>54 1/2</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Georgia</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-18-2553</i>	
17. INFORMANT <i>Ms Magnolia Mills</i> Address <i>95 West Ave, Bryn Mawr, Pa.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Pulmonary Edema</i> 4433x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive Cardiovascular disease</i> DUE TO (c) <i>5 yrs</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cachexia + inanition</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Sept. 1 1957</i> to <i>April 18 1960</i> , that (I) (we) last saw the deceased alive on <i>April 17 1960</i> , and that death occurred at <i>8 A.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Robert C. LaMar</i> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>4-23-60</i>	
22c. PHYSICIAN'S NAME (Type) <i>Robert C. LaMar</i>		22d. ADDRESS <i>104 Bay St. Snow Hill, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>April 20/60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Baptist Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Snow Hill, Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Walter E. Dennis</i> ADDRESS <i>Snow Hill, Md</i>		25a. REC'D BY REGISTRAR DATE <i>APR 25 '60</i>	
		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

CERTIFICATE OF DEATH

5132

[Faint, illegible handwriting throughout the form, likely bleed-through from the reverse side.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5191 MEDICAL EXAMINER'S CERTIFICATE OF DEATH **65178**
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY (RURAL)</u> c. LENGTH OF STAY IN lb <u>4 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> <u>3V01.4</u> d. STREET ADDRESS <u>5236 LINDEN HEIGHTS</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Isadore Conrad Franz</u> First Middle Last 4. DATE OF DEATH <u>April 28 1960</u> Month Day Year				5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>APRIL 3, 1884</u> 9. AGE (In years last birthday) <u>76 yrs.</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED TREASURER</u> 13. FATHER'S NAME <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ELECTRICAL UNION</u> 14. MOTHER'S MAIDEN NAME <u>Richard (discontinued)</u>		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MR. RICHARD H. FRANZ, 2628 MATTHEWS DR. BALTO 34 MD.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure sec</u> DUE TO <u>420-1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Artery Disease</u> DUE TO <u>degenerative myocarditis</u> (c) <u>degenerative myocarditis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>2 yrs</u> <u>2 yrs</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> @ <u>11 P.M.</u>							
ACTUAL SIGNATURE <u>Herman C. Rahlus</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>4/28/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/2/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE PARK</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burboye Berlin Md.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>MAY 2 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			
22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 1911

NAME OF DECEASED _____		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
AGE _____		OCCUPATION _____	
PLACE OF BIRTH _____		DATE OF BIRTH _____	
PLACE OF DEATH _____		DATE OF DEATH _____	
TIME OF DEATH _____		CAUSE OF DEATH _____	
MANNER OF DEATH _____		SIGNATURE OF EXAMINER _____	
NAME OF PHYSICIAN _____		SIGNATURE OF PHYSICIAN _____	
NAME OF FUNERAL HOME _____		SIGNATURE OF FUNERAL HOME _____	
NAME OF NEXT OF KIN _____		SIGNATURE OF NEXT OF KIN _____	
NAME OF WITNESS _____		SIGNATURE OF WITNESS _____	
NAME OF CORONER _____		SIGNATURE OF CORONER _____	
NAME OF JURY _____		SIGNATURE OF JURY _____	
NAME OF JUDGE _____		SIGNATURE OF JUDGE _____	
NAME OF CLERK _____		SIGNATURE OF CLERK _____	
NAME OF SHERIFF _____		SIGNATURE OF SHERIFF _____	
NAME OF DEPUTY SHERIFF _____		SIGNATURE OF DEPUTY SHERIFF _____	
NAME OF CONSTABLE _____		SIGNATURE OF CONSTABLE _____	
NAME OF JURY _____		SIGNATURE OF JURY _____	
NAME OF JUDGE _____		SIGNATURE OF JUDGE _____	
NAME OF CLERK _____		SIGNATURE OF CLERK _____	
NAME OF SHERIFF _____		SIGNATURE OF SHERIFF _____	
NAME OF DEPUTY SHERIFF _____		SIGNATURE OF DEPUTY SHERIFF _____	
NAME OF CONSTABLE _____		SIGNATURE OF CONSTABLE _____	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5192 MEDICAL EXAMINER'S CERTIFICATE OF DEATH **65179**
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Accomack ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Snow Hill			c. LENGTH OF STAY IN lb 4 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oak Hall 83x3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DARIUS Middle THOMAS Last HALL				4. DATE OF DEATH Month April Day 24 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 16, 1877		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Asa D. Hall				14. MOTHER'S MAIDEN NAME Mary Justice			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 228-14-3303		17. INFORMANT Address Claude E. Hall, Snow Hill, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis DUE TO (b) Serum Sickness DUE TO (c) Serum Sickness Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH (2)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE N. E. Sartorius M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) N. E. SARTORIUS, SR.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-27-60		22c. NAME OF CEMETERY OR CREMATORY Martle Cemetery		22d. LOCATION (City, town, or county) (State) Sanford Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Henry A. Watson				24a. REC'D BY REGISTRAR DATE MAY 2 '60		24b. REGISTRAR'S SIGNATURE William S. Francis	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any doubt is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

5184

CERTIFICATE OF DEATH

65180

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WORCESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS X BERLIN	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First IDA Middle VERA Last HASTINGS		4. DATE OF DEATH Month April Day 9 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 2, 1889
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) PARSONSBURG MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LEVIN DAVIS		14. MOTHER'S MAIDEN NAME SARA GIVENS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-32-6978	
17. INFORMANT MR. LOG HASTINGS		Address BERLIN MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage, 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) 10 day 5 yrs		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus Myocarditis Sclerotic			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 19 57 to April 9 , 19 60 , that I last saw the deceased alive on April 9 , 19 60 , and that death occurred at 7 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Herman A. Robbins M.D.		ADDRESS (Street, city, or town, state) Berlin, Md DATE SIGNED 4/4/60	
PHYSICIAN'S NAME (Type) Herman A. Robbins M. D.		Berlin, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4/14/60	22c. NAME OF CEMETERY OR CREMATORY ST. PAULS	22d. LOCATION (City, town, or county) (State) BERLIN MD
23. FUNERAL DIRECTOR'S SIGNATURE Anna A. Burboys ADDRESS Berlin Md		24a. REC'D BY REGISTRAR DATE APR 14 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

334X

5185 Item 1b, a, Film G261 4/27/60 iwk 65181

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WORCESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN, MD.		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Berlin Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MINNIE IRONSHIRE HOLLOWAY		4. DATE OF DEATH Month APRIL Day 19 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 6, 1884
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME HORACE F. HARMONSON		14. MOTHER'S MAIDEN NAME VIRGINIA LINGO	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NO	
17. INFORMANT MR. WILLIAM L. HOLLOWAY		Address OCEAN CITY MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 421.4 Acute Endocarditis DUE TO (b) Chr. Myocarditis DUE TO (c) Age Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost.			INTERVAL BETWEEN ONSET AND DEATH 3 wks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 1 - 1960 , to April 19 - 1960 , that (I) (we) last saw the deceased alive on 4-18 - 1960 , and that death occurred at 5:00 P. from the causes and on the date stated above.			
22a. SIGNATURE Chas. R. Law		22b. DATE SIGNED 4-21-1960	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Berlin Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4/21/60	23c. NAME OF CEMETERY OR CREMATORY EVERGREEN	23d. LOCATION (City, town, or county) (State) BERLIN MD
24. FUNERAL DIRECTOR'S SIGNATURE Anna R. Burbage		25a. REC'D BY REGISTRAR APR 22 '60	
ADDRESS Berlin Md.		25b. REGISTRAR'S SIGNATURE Charles S. Kline	

CHIEF CLERK
V. B. O'NEAL

RECORDED

MAY 14 1912

1912

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 185182
5193
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHALEYVILLE</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X WHALEYVILLE</u>	
		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>SARAH ELIZABETH HUDSON</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>10</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 28, 1878</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>Wicomico Co. MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSIAH CAREY</u>		14. MOTHER'S MAIDEN NAME <u>NANCY CAREY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>Mr. URIAH HUDSON, WHALEYVILLE MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chr. Hypertension</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>26 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-30-</u> , 19 <u>60</u> , to <u>4-10-</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4-10-</u> , 19 <u>60</u> , and that death occurred at <u>2:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chas. R. Law</u>		ADDRESS (Street, city or town, state) <u>Berlin Md.</u> DATE SIGNED <u>4-12-1960</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/13/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>NEW HOPE</u>		22d. LOCATION (City, town, or county) (State) <u>WILLARDS (RED) MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burhage</u>		ADDRESS <u>Berlin Md.</u>	
24a. REC'D BY REGISTRAR <u>APR 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraw</u>	

100000

CERTIFICATE OF DEATH

331X

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Race", "Date of Birth", "Date of Death", "Cause of Death", "Place of Death", "Signature", and "Registrar" are faintly visible.]

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5194 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 65183

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Pocomoke City		c. LENGTH OF STAY IN 1b 3 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First IDA Middle -- Last JESTER		4. DATE OF DEATH Month April Day 21 Year 19 60	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 11, 1888
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME George W. Jones		14. MOTHER'S MAIDEN NAME Gaddie Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mrs Lessie Lankford, Snow Hill, Md.		Address RFD 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE N. E. Sartorius Sr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) N. E. SARTORIUS SR.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-27-60	
22c. NAME OF CEMETERY OR CREMATORY Georgetown Cemetery		22d. LOCATION (City, town, or county) (State) Rural Pocomoke City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert H. Watson		ADDRESS Pocomoke City, Md.	
24a. REC'D BY REGISTRAR DATE MAY 2 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [Illegible]

2. SEX: [Illegible]

3. AGE: [Illegible]

4. DATE OF DEATH: [Illegible]

5. PLACE OF DEATH: [Illegible]

6. OCCUPATION: [Illegible]

7. CAUSE OF DEATH: [Illegible]

8. MANNER OF DEATH: [Illegible]

9. SIGNATURE OF EXAMINER: [Illegible]

10. DATE OF EXAMINATION: [Illegible]

11. PLACE OF EXAMINATION: [Illegible]

12. SIGNATURE OF WITNESS: [Illegible]

13. DATE OF WITNESS: [Illegible]

14. PLACE OF WITNESS: [Illegible]

15. SIGNATURE OF SECOND WITNESS: [Illegible]

16. DATE OF SECOND WITNESS: [Illegible]

17. PLACE OF SECOND WITNESS: [Illegible]

18. SIGNATURE OF THIRD WITNESS: [Illegible]

19. DATE OF THIRD WITNESS: [Illegible]

20. PLACE OF THIRD WITNESS: [Illegible]

21. SIGNATURE OF FOURTH WITNESS: [Illegible]

22. DATE OF FOURTH WITNESS: [Illegible]

23. PLACE OF FOURTH WITNESS: [Illegible]

24. SIGNATURE OF FIFTH WITNESS: [Illegible]

25. DATE OF FIFTH WITNESS: [Illegible]

26. PLACE OF FIFTH WITNESS: [Illegible]

27. SIGNATURE OF SIXTH WITNESS: [Illegible]

28. DATE OF SIXTH WITNESS: [Illegible]

29. PLACE OF SIXTH WITNESS: [Illegible]

30. SIGNATURE OF SEVENTH WITNESS: [Illegible]

31. DATE OF SEVENTH WITNESS: [Illegible]

32. PLACE OF SEVENTH WITNESS: [Illegible]

33. SIGNATURE OF EIGHTH WITNESS: [Illegible]

34. DATE OF EIGHTH WITNESS: [Illegible]

35. PLACE OF EIGHTH WITNESS: [Illegible]

36. SIGNATURE OF NINTH WITNESS: [Illegible]

37. DATE OF NINTH WITNESS: [Illegible]

38. PLACE OF NINTH WITNESS: [Illegible]

39. SIGNATURE OF TENTH WITNESS: [Illegible]

40. DATE OF TENTH WITNESS: [Illegible]

41. PLACE OF TENTH WITNESS: [Illegible]

42. SIGNATURE OF ELEVENTH WITNESS: [Illegible]

43. DATE OF ELEVENTH WITNESS: [Illegible]

44. PLACE OF ELEVENTH WITNESS: [Illegible]

45. SIGNATURE OF TWELFTH WITNESS: [Illegible]

46. DATE OF TWELFTH WITNESS: [Illegible]

47. PLACE OF TWELFTH WITNESS: [Illegible]

48. SIGNATURE OF THIRTEENTH WITNESS: [Illegible]

49. DATE OF THIRTEENTH WITNESS: [Illegible]

50. PLACE OF THIRTEENTH WITNESS: [Illegible]

51. SIGNATURE OF FOURTEENTH WITNESS: [Illegible]

52. DATE OF FOURTEENTH WITNESS: [Illegible]

53. PLACE OF FOURTEENTH WITNESS: [Illegible]

54. SIGNATURE OF FIFTEENTH WITNESS: [Illegible]

55. DATE OF FIFTEENTH WITNESS: [Illegible]

56. PLACE OF FIFTEENTH WITNESS: [Illegible]

57. SIGNATURE OF SIXTEENTH WITNESS: [Illegible]

58. DATE OF SIXTEENTH WITNESS: [Illegible]

59. PLACE OF SIXTEENTH WITNESS: [Illegible]

60. SIGNATURE OF SEVENTEENTH WITNESS: [Illegible]

61. DATE OF SEVENTEENTH WITNESS: [Illegible]

62. PLACE OF SEVENTEENTH WITNESS: [Illegible]

63. SIGNATURE OF EIGHTEENTH WITNESS: [Illegible]

64. DATE OF EIGHTEENTH WITNESS: [Illegible]

65. PLACE OF EIGHTEENTH WITNESS: [Illegible]

66. SIGNATURE OF NINETEENTH WITNESS: [Illegible]

67. DATE OF NINETEENTH WITNESS: [Illegible]

68. PLACE OF NINETEENTH WITNESS: [Illegible]

69. SIGNATURE OF TWENTIETH WITNESS: [Illegible]

70. DATE OF TWENTIETH WITNESS: [Illegible]

71. PLACE OF TWENTIETH WITNESS: [Illegible]

72. SIGNATURE OF TWENTY-FIRST WITNESS: [Illegible]

73. DATE OF TWENTY-FIRST WITNESS: [Illegible]

74. PLACE OF TWENTY-FIRST WITNESS: [Illegible]

75. SIGNATURE OF TWENTY-SECOND WITNESS: [Illegible]

76. DATE OF TWENTY-SECOND WITNESS: [Illegible]

77. PLACE OF TWENTY-SECOND WITNESS: [Illegible]

78. SIGNATURE OF TWENTY-THIRD WITNESS: [Illegible]

79. DATE OF TWENTY-THIRD WITNESS: [Illegible]

80. PLACE OF TWENTY-THIRD WITNESS: [Illegible]

81. SIGNATURE OF TWENTY-FOURTH WITNESS: [Illegible]

82. DATE OF TWENTY-FOURTH WITNESS: [Illegible]

83. PLACE OF TWENTY-FOURTH WITNESS: [Illegible]

84. SIGNATURE OF TWENTY-FIFTH WITNESS: [Illegible]

85. DATE OF TWENTY-FIFTH WITNESS: [Illegible]

86. PLACE OF TWENTY-FIFTH WITNESS: [Illegible]

87. SIGNATURE OF TWENTY-SIXTH WITNESS: [Illegible]

88. DATE OF TWENTY-SIXTH WITNESS: [Illegible]

89. PLACE OF TWENTY-SIXTH WITNESS: [Illegible]

90. SIGNATURE OF TWENTY-SEVENTH WITNESS: [Illegible]

91. DATE OF TWENTY-SEVENTH WITNESS: [Illegible]

92. PLACE OF TWENTY-SEVENTH WITNESS: [Illegible]

93. SIGNATURE OF TWENTY-EIGHTH WITNESS: [Illegible]

94. DATE OF TWENTY-EIGHTH WITNESS: [Illegible]

95. PLACE OF TWENTY-EIGHTH WITNESS: [Illegible]

96. SIGNATURE OF TWENTY-NINTH WITNESS: [Illegible]

97. DATE OF TWENTY-NINTH WITNESS: [Illegible]

98. PLACE OF TWENTY-NINTH WITNESS: [Illegible]

99. SIGNATURE OF THIRTIETH WITNESS: [Illegible]

100. DATE OF THIRTIETH WITNESS: [Illegible]

101. PLACE OF THIRTIETH WITNESS: [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5195

CERTIFICATE OF DEATH

65184

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stockton		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bay Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRED Middle BREM Last JONES		4. DATE OF DEATH Month April Day 20 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 6, 1893
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George M. Jones		14. MOTHER'S MAIDEN NAME Sarah A. Conner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW 1 218-12-1320	
17. INFORMANT Mrs Maude M. Jones, Stockton, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 1958 , to April 20, 1960 , that I last saw the deceased alive on Feb 1960 , and that death occurred at 1 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE C. E. Critcher M.D. Mar 25, 1960 PHYSICIAN'S NAME (Type) C. E. CRITCHER, M.D. New Church, Virginia			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-24-60	
22c. NAME OF CEMETERY Wesley Methodist		22d. LOCATION (City, town, or county) (State) Stockton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Watson		24a. REC'D BY REGISTRAR APR 25 '60	
ADDRESS Pocomoke City, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

1. PLACE OF BIRTH		2. PLACE OF DEATH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
3. SEX		4. AGE	
MALE		35	
5. OCCUPATION		6. CAUSE OF DEATH	
LABORER		HEART DISEASE	
7. DATE OF DEATH		8. TIME OF DEATH	
JANUARY 15, 1913		10:00 AM	
9. SIGNATURE OF DECEASED		10. SIGNATURE OF WITNESSES	
[Signature]		[Signature]	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF CORONER	
[Signature]		[Signature]	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF CLERK	
[Signature]		[Signature]	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WORCESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN		c. LENGTH OF STAY IN 1b X BERLIN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last EDNA FRANCIS KELLY		4. DATE OF DEATH Month Day Year APRIL 4 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 27, 1895
9. AGE (In years lost birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) NEW BEDFORD MASS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALBERT M. GRAY		14. MOTHER'S MAIDEN NAME EMILY F. BARKER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT MRS ETHEL I. JOHNSON, MARIAN, MASS.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocarditis 444X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) hypertension DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-4-60 to 4-4-60 that I last saw the deceased alive on 4-4-60 , 19 60 and that death occurred at 2:00 M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Clifford E. Schott M.D. Berlin Md			
PHYSICIAN'S NAME (Type) CLIFFORD E SCHOTT MD BERLIN MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4/9/60	22c. NAME OF CEMETERY OR CREMATORY OLD LANDING	22d. LOCATION (City, town, or county) (State) MARIAN MASS.
23. FUNERAL DIRECTOR'S SIGNATURE Anna A. Burbage ADDRESS Berlin Md.		24a. REC'D BY REGISTRAR DATE APR 8 '60	
		24b. REGISTRAR'S SIGNATURE Clifford E. Schott	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1915

RECEIVED

212

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

5186

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1865186

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>R.F.D. 2 Bx. 3</u>			
3. NAME OF DECEASED (Type or print) First <u>Willard</u> Middle <u>Randolph</u> Last <u>Marshall</u>				4. DATE OF DEATH Month <u>Apr.</u> Day <u>23</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 30, 1934</u>	
9. AGE (In years last birthday) <u>25</u> yrs.		IF UNDER 1 YEAR Months <u>25</u> Days <u>25</u> Hours <u>25</u> Min.		IF UNDER 24 HRS. Months <u>25</u> Days <u>25</u> Hours <u>25</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Oil Plant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>							
13. FATHER'S NAME <u>Kanzell Marshall</u>				14. MOTHER'S MAIDEN NAME <u>Sara Ginn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>220-3284</u>			
17. INFORMANT <u>Elizabeth Marshall</u>				Address <u>Pocomoke City, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage Lung</u> DUE TO <u>981X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fire arms - (Bullets & Gun shot)</u> DUE TO <u>2 hours</u> (c) <u>Interval between onset and death</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot twice through chest - Bullet entered once in lower abdomen - Gun shot wound</u>			
20c. TIME OF INJURY Month, Day, Year <u>Apr. 23, 1960</u> Hour <u>2</u> a. m. <u>2</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>At home</u>				20f. (City or town) <u>Sign Post Accomack, Va.</u> (County) <u>Stafford</u> (State) <u>Va.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>N. F. Sartorius Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>N. F. Sartorius</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Apr. 26, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Cem.</u>		22d. LOCATION (City, town, or county) <u>Stafford, Md.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton</u>				ADDRESS <u>New Church, Va.</u>		24a. REC'D BY REGISTRAR <u>DATE MAY 2 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanks</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

5197

CERTIFICATE OF DEATH

65187
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>		c. LENGTH OF STAY IN 1b <u>H's</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route # 2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Girl</u> Last <u>PURNELL</u>		4. DATE OF DEATH Month <u>4</u> Day <u>22</u> Year <u>60</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARried <input type="checkbox"/> NEVER MARried <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-22-60</u>
9. AGE (In years last birthday) yrs. <u>30</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Milton Purnell - 29 YRS</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE PURNELL - 25 YRS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>INFORMANT Mother</u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>770X</u> IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>5+ mos</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____ to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>9:00 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ivory U. Sully, Jr. M.D.</u>		ADDRESS (Street, city or town, state) <u>Berlin, Md</u> DATE SIGNED <u>4/26/60</u>	
PHYSICIAN'S NAME (Type) <u>Ivory U. Sully, Jr. M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-23-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Berlin Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thornton B. Jolley</u> ADDRESS <u>Salisbury Md</u>		24a. REC'D BY REGISTRAR <u>MAY 2 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinner</u>	

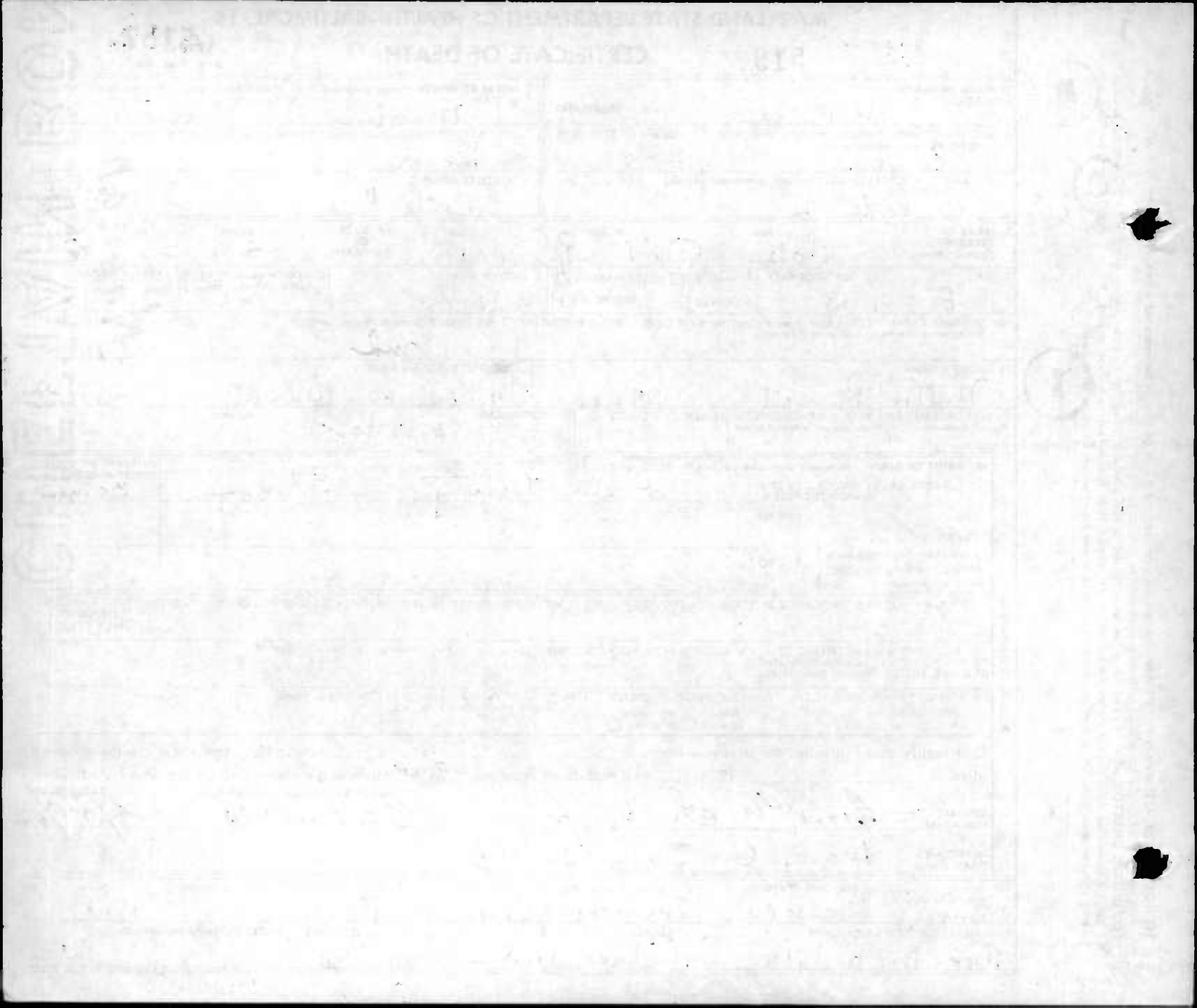
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 5-58

1000254XV1



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5198

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5188
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Worcester MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Pocomoke City		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Pocomoke City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD 3			d. STREET ADDRESS RFD 3		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MARY Middle ELLEN Last REDDEN			4. DATE OF DEATH Month April Day 23 Year 1960		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 27, 1937		9. AGE (In years last birthday) 22 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Ray F. Redden			14. MOTHER'S MAIDEN NAME Doris May Truitt		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Ray F. Redden, RFD 3, Pocomoke City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Epileptic Attack DUE TO (b) Epilepsy (Psychomotor Grand Mal) DUE TO (c) --- CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE N. E. Sartorius, Sr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/25/60	
EXAMINER'S NAME (Type) N. E. SARTORIUS, SR.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-25-60		22c. NAME OF CEMETERY Bethany Methodist	
22d. LOCATION (City, town, or county) Pocomoke City, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE Robert N. Watson		ADDRESS Pocomoke City, Md.		24a. REC'D BY REGISTRAR APR 27 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus					

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5112

COUNTY OF BALTIMORE CITY OF BALTIMORE		DECEASED NAME: [Name]		SEX: [Male/Female]		AGE: [Age]		DATE OF BIRTH: [Date]		PLACE OF BIRTH: [Place]	
OCCUPATION: [Occupation]		MARITAL STATUS: [Married/Single/etc.]		CAUSE OF DEATH: [Cause]		MANNER OF DEATH: [Natural/Accident/etc.]		TIME OF DEATH: [Time]		PLACE OF DEATH: [Place]	
SIGNATURE OF EXAMINER: [Signature]		SIGNATURE OF WITNESS: [Signature]		SIGNATURE OF WITNESS: [Signature]		SIGNATURE OF WITNESS: [Signature]		SIGNATURE OF WITNESS: [Signature]		SIGNATURE OF WITNESS: [Signature]	
DATE: [Date]		TIME: [Time]		PLACE: [Place]		PLACE: [Place]		PLACE: [Place]		PLACE: [Place]	

NO. 1

NO. 2

NO. 3

NO. 4

NO. 5

NO. 6

NO. 7

NO. 8

NO. 9

NO. 10

NO. 11

NO. 12

NO. 13

NO. 14

NO. 15

NO. 16

NO. 17

NO. 18

NO. 19

NO. 20

NO. 21

NO. 22

NO. 23

NO. 24

NO. 25

NO. 26

NO. 27

NO. 28

NO. 29

NO. 30

NO. 31

NO. 32

NO. 33

NO. 34

NO. 35

NO. 36

NO. 37

NO. 38

NO. 39

NO. 40

NO. 41

NO. 42

NO. 43

NO. 44

NO. 45

NO. 46

NO. 47

NO. 48

NO. 49

NO. 50

NO. 51

NO. 52

NO. 53

NO. 54

NO. 55

NO. 56

NO. 57

NO. 58

NO. 59

NO. 60

NO. 61

NO. 62

NO. 63

NO. 64

NO. 65

NO. 66

NO. 67

NO. 68

NO. 69

NO. 70

NO. 71

NO. 72

NO. 73

NO. 74

NO. 75

NO. 76

NO. 77

NO. 78

NO. 79

NO. 80

NO. 81

NO. 82

NO. 83

NO. 84

NO. 85

NO. 86

NO. 87

NO. 88

NO. 89

NO. 90

NO. 91

NO. 92

NO. 93

NO. 94

NO. 95

NO. 96

NO. 97

NO. 98

NO. 99

NO. 100

5199

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishopville				c. LENGTH OF STAY IN 1b 30Yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION XX				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishopville			
f. STREET ADDRESS XX				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WALTER Middle S. Last RINGLER				4. DATE OF DEATH Month April Day 21 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 8, 1883	
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance				10b. KIND OF BUSINESS OR INDUSTRY Agent			
11. BIRTHPLACE (State or foreign country) Delaware				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Seth Ringler				14. MOTHER'S MAIDEN NAME Lida Holton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 222-05-3914			
17. INFORMANT Mrs. Amanda Ringler Bishopville, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic heart disease DUE TO several yrs (c) several yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH a few minutes 4 several yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Bishopville				20g. (County) Worcester		20h. (State) Md.	
21. I certify that I attended the deceased from Jan 1960 to Death , that I last saw the deceased alive on 21 Apr 1960 , and that death occurred at 1:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Earl B. McFadden				ADDRESS (Street, city or town, state) Selbyville, Del.			
PHYSICIAN'S NAME (Type) Earl B. McFadden				DATE SIGNED 23 Apr '60			
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF 4/24/60		22c. NAME OF CEMETERY OR CREMATORY I. O. O. F.		22d. LOCATION (City, town, or county) (State) Bishopville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley Selbyville, Del.				24a. REC'D BY REGISTRAR APR 27 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

65190

Reg. Dist. No.

5200

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Prince George's County, Maryland</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin Md. Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin Md. Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>at home</u>				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Hannah</u> Last <u>Thomas</u>				4. DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 11, 1878</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>82</u> Days <u>82</u> Hours <u>82</u> Min. <u>82</u>		IF UNDER 24 HRS. Months <u>82</u> Days <u>82</u> Hours <u>82</u> Min. <u>82</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Curtis Duke</u>				14. MOTHER'S MAIDEN NAME <u>Mora Long</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Wm. Thomas</u> Address <u>Berlin Md</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis Chronic</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Atherosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> <u>5-10 yrs</u> <u>5-10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> a. m. <u>—</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>							
21. I certify that I attended the deceased from <u>1950</u> , 19 <u>—</u> , to <u>4-27</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4-27</u> , 19 <u>60</u> , and that death occurred at <u>1:31 A.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Waldens Maryland</u>						DATE SIGNED <u>—</u>	
ACTUAL SIGNATURE <u>Frank R. Lewis</u>				M.D. <u>Waldens Maryland</u>			
PHYSICIAN'S NAME (Type) <u>Frank R. Lewis M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-30-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Buckingham</u>		22d. LOCATION (City, town, or county) (State) <u>Berlin Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burby</u> ADDRESS <u>Berlin Md</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>MAY 2 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Christina L. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any certificate is necessary, please execute and forward to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1 96711 P
5187 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05191
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Ma</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>		c. LENGTH OF STAY IN 1b <u>14 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>42 Pocomoke City</u>	
3. NAME OF DECEASED (Type or print) <u>Wm</u> First Middle <u>Alexander Tucker</u> Last		4. DATE OF DEATH Month <u>April</u> Day <u>7th</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 15 - 1912</u>
9. AGE (in years last birthday) <u>47 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labourer</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Appliance</u>	
12. BIRTHPLACE (State or foreign country) <u>Atlanta Georgia</u>		13. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14. FATHER'S NAME <u>David Tucker</u>		15. MOTHER'S MAIDEN NAME <u>Mary Ellen Tucker</u>	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		17. SOCIAL SECURITY NO. <u>252-09-223</u>	
18. INFORMANT <u>Edna H Tucker</u> Address <u>Pocomoke City, Md</u>		19. INTERVAL BETWEEN ONSET AND DEATH <u>Brief</u>	
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>929.3 Pulmonary Edema (Severe)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Drowning in brine</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>	
22a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell flat on abdomen with head bent over and immersed in a tank of freezing brine</u>	
23a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>1960</u>		23b. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
24a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Pocomoke City, Worc. Md.</u>		24b. (City or town) <u>Pocomoke City</u> (County) <u>Worc.</u> (State) <u>Md.</u>	
25. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
26. ACTUAL SIGNATURE <u>N.E. Sartorius Sr.</u> M.D.		27. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
28. EXAMINER'S NAME (Type) <u>N.E. Sartorius Sr.</u>		29. DATE SIGNED <u>4-7-60</u>	
30a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		30b. DATE THEREOF <u>4-16-60</u>	
31a. NAME OF CEMETERY OR CREMATORY <u>Atlanta</u>		31b. LOCATION (City, town, or county) <u>Atlanta Georgia</u> (State)	
32. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - Newchurch, Va.</u> ADDRESS		33. REC'D BY REGISTRAR <u>APR 21 '60</u>	
34. REGISTRAR'S SIGNATURE <u>Charles E. Hines</u>		35. REGISTRAR'S SIGNATURE	

Hand med. Ex. here -
reported "Drowning"

5201

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WORCESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BISHOP R.F.D.		c. LENGTH OF STAY IN 1b 45YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D.2		d. STREET ADDRESS R.F.D.2	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last M. EDGAR WATERS		4. DATE OF DEATH Month Day Year 4 3 1960	
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/8/1883
9. AGE (In years last birthday) 76		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY FARMING	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME MORRIS WATERS		14. MOTHER'S MAIDEN NAME SARAH HUDSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT JOSEPHINE WATERS BISHOP, MD. R.F.D.2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio-vascular Disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (1) Diabetes mellitus (2) Senility INTERVAL BETWEEN ONSET AND DEATH 4 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-23 , 19 56 , to 4-2 , 19 60 , that I last saw the deceased alive on 4-2 , 19 60 , and that death occurred at 4:35p M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Ivory U. Sully Jr. M.D.		ADDRESS (Street, city or town, state) Berlin, Md.	
PHYSICIAN'S NAME (Type) Ivory U. Sully Jr. M.D.		DATE SIGNED 4/4/60	
22a. BURIAL, CREMATION, or other disposition (Specify) BURIAL		22b. DATE THEREOF 4/6/60	
22c. NAME OF CEMETERY OR CREMATORY SARAH DUKES CEMETERY		22d. LOCATION (City, town, or county) (State) BISHOP, MD. R.F.D.	
23. FUNERAL DIRECTOR'S SIGNATURE Ronald James		ADDRESS MILLSBORO, DEL.	
24a. REC'D BY REGISTRAR DATE APR 7 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

MEDICAL CERTIFICATION

TO HO... AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

103103

CERTIFICATE OF DEATH

Form 100-10

1. NAME OF DECEASED JOSEPHINE WILSON		2. SEX F		3. AGE 70		4. DATE OF DEATH 11/13/1983		5. PLACE OF DEATH HOSPITAL	
6. FULL NAME OF DECEASED JOSEPHINE WILSON		7. DATE OF BIRTH 11/13/1913		8. PLACE OF BIRTH NEW YORK		9. OCCUPATION HOUSEWIFE		10. MARITAL STATUS WIDOW	
11. NAME OF DECEASED JOSEPHINE WILSON		12. SEX F		13. AGE 70		14. DATE OF DEATH 11/13/1983		15. PLACE OF DEATH HOSPITAL	
16. FULL NAME OF DECEASED JOSEPHINE WILSON		17. DATE OF BIRTH 11/13/1913		18. PLACE OF BIRTH NEW YORK		19. OCCUPATION HOUSEWIFE		20. MARITAL STATUS WIDOW	
21. NAME OF DECEASED JOSEPHINE WILSON		22. SEX F		23. AGE 70		24. DATE OF DEATH 11/13/1983		25. PLACE OF DEATH HOSPITAL	
26. FULL NAME OF DECEASED JOSEPHINE WILSON		27. DATE OF BIRTH 11/13/1913		28. PLACE OF BIRTH NEW YORK		29. OCCUPATION HOUSEWIFE		30. MARITAL STATUS WIDOW	
31. NAME OF DECEASED JOSEPHINE WILSON		32. SEX F		33. AGE 70		34. DATE OF DEATH 11/13/1983		35. PLACE OF DEATH HOSPITAL	
36. FULL NAME OF DECEASED JOSEPHINE WILSON		37. DATE OF BIRTH 11/13/1913		38. PLACE OF BIRTH NEW YORK		39. OCCUPATION HOUSEWIFE		40. MARITAL STATUS WIDOW	
41. NAME OF DECEASED JOSEPHINE WILSON		42. SEX F		43. AGE 70		44. DATE OF DEATH 11/13/1983		45. PLACE OF DEATH HOSPITAL	
46. FULL NAME OF DECEASED JOSEPHINE WILSON		47. DATE OF BIRTH 11/13/1913		48. PLACE OF BIRTH NEW YORK		49. OCCUPATION HOUSEWIFE		50. MARITAL STATUS WIDOW	
51. NAME OF DECEASED JOSEPHINE WILSON		52. SEX F		53. AGE 70		54. DATE OF DEATH 11/13/1983		55. PLACE OF DEATH HOSPITAL	
56. FULL NAME OF DECEASED JOSEPHINE WILSON		57. DATE OF BIRTH 11/13/1913		58. PLACE OF BIRTH NEW YORK		59. OCCUPATION HOUSEWIFE		60. MARITAL STATUS WIDOW	
61. NAME OF DECEASED JOSEPHINE WILSON		62. SEX F		63. AGE 70		64. DATE OF DEATH 11/13/1983		65. PLACE OF DEATH HOSPITAL	
66. FULL NAME OF DECEASED JOSEPHINE WILSON		67. DATE OF BIRTH 11/13/1913		68. PLACE OF BIRTH NEW YORK		69. OCCUPATION HOUSEWIFE		70. MARITAL STATUS WIDOW	
71. NAME OF DECEASED JOSEPHINE WILSON		72. SEX F		73. AGE 70		74. DATE OF DEATH 11/13/1983		75. PLACE OF DEATH HOSPITAL	
76. FULL NAME OF DECEASED JOSEPHINE WILSON		77. DATE OF BIRTH 11/13/1913		78. PLACE OF BIRTH NEW YORK		79. OCCUPATION HOUSEWIFE		80. MARITAL STATUS WIDOW	
81. NAME OF DECEASED JOSEPHINE WILSON		82. SEX F		83. AGE 70		84. DATE OF DEATH 11/13/1983		85. PLACE OF DEATH HOSPITAL	
86. FULL NAME OF DECEASED JOSEPHINE WILSON		87. DATE OF BIRTH 11/13/1913		88. PLACE OF BIRTH NEW YORK		89. OCCUPATION HOUSEWIFE		90. MARITAL STATUS WIDOW	
91. NAME OF DECEASED JOSEPHINE WILSON		92. SEX F		93. AGE 70		94. DATE OF DEATH 11/13/1983		95. PLACE OF DEATH HOSPITAL	
96. FULL NAME OF DECEASED JOSEPHINE WILSON		97. DATE OF BIRTH 11/13/1913		98. PLACE OF BIRTH NEW YORK		99. OCCUPATION HOUSEWIFE		100. MARITAL STATUS WIDOW	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, NEW YORK CITY, AND IN THE OFFICE OF THE CLERK OF THE SUPREME COURT, NEW YORK COUNTY, NEW YORK.